REFERRAL FORM

Daniel Robbins, MD
Board-Certified Orthopedic Surgeon
Fellowship trained

Robert Giering, MD
Board-Certified PM&R / Pain Management
Fellowship trained

3505 Richville Road, Manchester Center, VT 05255 | Phone: 802-366-1144 | Fax: 802-768-8466
www.TaconicSpine.com

1 Referring Physician Information

Contact Person ____________ Date ____________

Referring Physician's Name ____________ NPI: ____________

Office Address ____________

Phone ____________ Fax ____________

Primary Care Physician ____________ Phone ____________

2 Patient Information

Patient First Name ____________ Patient Last Name ____________ DOB (M/D/Y) ____________

Patient Phone # ____________ Emergency Contact ____________ Phone ____________

Address ____________ SSN: ____________

3 Insurance

Insurance Information ____________ Responsible Party Information ____________

Secondary Insurance Information (if available) ____________

4 Imaging

Imaging completed ____________ Person responsible ____________ When & Where ____________

Imaging completed ____________ Person responsible ____________ When & Where ____________

Please include any progress notes, operative reports, and imaging which has been completed within four (4) months of appointment with our office. Patient may need to bring imaging media to our office at time of appointment. Please make this available to the patient.

Further Concerns: ____________

5 Referred for:

Physical Medicine/Pain Medicine: ☐ Eval/Treat ☐ 2nd opinion only

Orthopedic Spine Surgeon: ☐ Eval/Treat ☐ 2nd opinion only

Physical Therapy: ☐ As indicated

☐ PT only (I will manage other care)

☐ No PT (I will manage PT)

Electrodiagnostics (EMG/NCV): ☐ Routine ☐ Urgent

☐ As indicated by Diagnosis/Symptoms

☐ Specific request ____________

Diagnostic/Therapeutic Injections:

☐ As indicated by Diagnosis/Symptoms

☐ Specific request ____________

Level ____________

☐ Routine ☐ Urgent

6 Authorization

Doctor Signature ____________ Date ____________ Contact Telephone ____________